

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
Application for Privileges
N.J.A.C. 13:35-4A.12

PLASTIC AND RECONSTRUCTIVE SURGERY

Plastic Surgery Procedures:

PRIVILEGE CRITERIA

1. Attestation (Attachment 1 - in attestation format provided)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number and type of procedures in plastic surgery which I performed in the last two years with acceptable results for patients of all age groups, except age groups specifically excluded from my practice, **plus** through additional material below.

2. Training (Attachments 2A and, depending upon privileges requested, Attachments 2B and 2C)

I am providing, as Attachment 2A, documentary evidence of **one** of the following:

(1) Current certification in plastic surgery granted by the American Board of Plastic and Reconstructive Surgery or the American Osteopathic Board of Surgery or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Successful completion of an ACGME/AOA accredited residency training program in plastic surgery, **OR**

(3) Supervised training in residency or fellowship or other equivalent experience in _____ **(another field) AND** active participation in examination process leading to certification in plastic surgery.

Use of Laser (Attachment 2B):

In addition to documentation of general surgical training, for privileges for use of laser, I am providing, as **Attachment 2B**, documentary evidence of **one** of the following:

(1) Completion of a laser training program sponsored by an ACCME or AOA accredited provider of Category I CME documenting laser care, physics and clinical indications for utilization of the specific laser **and successful performance of laser procedures using the specific laser under direct clinical supervision**, or

(2) Documentation from the program director of an accredited residency training program attesting to the training in specific laser therapy during residency training.

Procedures Requiring Additional Training (Attachment 2C)

Licensee Name: _____ License Number: _____

I have attached, as Attachment(s) 2C, documentary evidence of the required additional training for each of the following procedures, if privileges are requested for these procedures:

- Surgery of the hand

additional training:

Documentation of completion of a specific fellowship in Surgery of the hand; **OR**

Documentation from the program director of an accredited residency training program attesting to the training during residency in Surgery of the hand;

PLUS

Documentation from a privileged physician who has directly observed my successful performance or participation in Surgery of the hand.

- Liposuction

additional training:

- Documentation showing inclusion of, and my successful completion of liposuction training in the course of instruction in the accredited surgical specialty training program; **OR**
- Documentation showing my completion of a liposuction training course that is sponsored by an Accreditation Council for Continuing Medical Education (ACCME) or AOA accredited provider of Category I CME, including Category I providers accredited by their state medical societies through ACCME's state recognition program, and which provides at least three (3) hours of training in a bioskills cadaver laboratory and which also **meets the criteria for a minimum of eight (8) hours of Category 1 credit towards the Physician's Recognition Award of the American Medical Association or has been approved by the American Osteopathic Association for a minimum of eight (8) credit hours of Category 1 continuing medical education ("CME")**;

3. Record Review/Clinical Observation (Attachment 3 and, depending upon privileges requested, Attachment 3A- in format provided):

References - Names, addresses and specialty, residency or observation only -

I am providing, as Attachment 3, the names, addresses and specialty of three plenary licensed physicians who will directly submit references addressing my current competence based on their personal knowledge obtained either during a residency training completed during the two years preceding the date of this application or through personal observation during the two years preceding the date of this application.

A. Reference for Requested Procedure(s) requiring additional training

Licensee Name: _____ License Number: _____

I am providing, as Attachment 3A, the name, address and specialty of a privileged physician who has directly observed my successful performance or participation in the **requested** procedure(s). and whom I have asked to submit directly a reference addressing my current competence based on that physician's personal knowledge obtained through personal observation of my successful performance or participation in the requested procedure.

4. Log of procedures (Attachment 4A, for each privileges requested - in format provided)

I am providing, as Attachment 4A, a **separate log** listing all patients for whom, in an office setting or licensed ambulatory care facility setting during the two years preceding the date of the application, I performed each of the procedures for which I am requesting privileges. Each log includes a patient number, the type of anesthesia service provided, the surgery or special procedure performed and the date(s) of service. Patient names and other identifying data are redacted.

I am maintaining **in my office** a list or other means to identify the patient, based on the number included in the log.

Within each log, I have identified any patients contained in the log who have experienced complications relating to my performance of surgery or special procedures in an office setting or licensed ambulatory care facility setting and their resulting outcomes.

As part of the application for privileges process, from the logs I am providing, at least 5 cases, **with personal identifiers redacted**, that are representative of the type(s) of procedures for which I requested privileges, will be selected and I will be asked to provide patient records (or pertinent portions), along with a completed case summary form for each.

DELINEATION OF PRIVILEGES

I have checked the column on the left of those privileges listed below to indicate those procedures for which I do not hold hospital privileges and for which I am requesting alternative privileges to perform these procedure(s) in the office setting. I have attached additional materials, including documentation of successful completion of additional training, as was noted above as Attachments 2B, 2C, and 3A, if I am requesting privileges for the specific procedure which requires additional training, including use of laser.

Requested Privileges

TREATMENT OF SKIN NEOPLASMS, DISEASES AND TRAUMA
Scar revisions - see also laser

SURGERY OF THE BREAST

_____ Breast augmentation
_____ Breast reduction

Licensee Name: _____ License Number: _____

_____ Mastopexy

TREATMENT OF FACIAL DISEASES AND INJURIES INCLUDING MAXILLOFACIAL STRUCTURES

_____ Nose deformity/ septal surgery
_____ Ear deformity
_____ Jaw deformity/ chin augmentation
_____ Eyelid deformity

SURGERY OF THE HAND AND EXTREMITIES - Requires additional training.

_____ Hand wounds
_____ Tendon injuries (flexor, extensor)
_____ Reductions of **closed** fractures of the hand and/or wrist with anesthesia services
_____ Nerve injuries

COMPLEX WOUND HEALING AND BURN TREATMENT

_____ Acute superficial or partial thickness burns covering less than 20% of body surface area in adults (other than hands, feet, head, neck or perineum) with anesthesia services

COSMETIC SURGERY

_____ Facial contouring
_____ Therapeutic injections for contour or scar modifications
_____ Cosmetic tattooing of eyelids
_____ Blepharoplasty
_____ Liposuction - **Requires additional training**
_____ Rhinoplasty
_____ Chin augmentation
_____ Skin lesion, subcutaneous skin lesion
_____ Other - Please specify and provide supporting documentation on a separate page: _____

Use of Laser:

Requires additional training in specific laser use.

_____ Scar revisions: Tunable dye or Ruby

Please specify procedure(s) and laser (for each) and provide supporting documentation on a separate page: _____

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me or if the materials submitted by me are willfully false, I am subject to punishment.

Licensee Name: _____ License Number: _____

Signature and printed name of Applicant

Date

Below this line for Administration Use Only

Application Tracking Record:

Initial Receipt Date of Application _____
Transmittal Date to Outsourcing Entity _____
Supplemental Information Requested _____
Supplemental Information Received _____
Outsourcing Entity Recommendation _____
Outsourcing Entity Reviewer _____
Board Committee Review Date _____
Board Disposition Date _____

Licensee Name: _____ License Number: _____